oneeapp
One Stop Access to Health Insurance

Application Summary

Generated By	Ernesto Reynoso
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Household Information

Application ID
Creation Date

Primary Informant Name
In Household
Entity ID
Preferred Spoken Language by Primary Informant
Preferred Written Language by Primary Informant

Application Created By
Assistor Phone Number
Assistor Location
Assistor Organization
Assistor Email
Number of Persons
Adults
Children
Unborn Children

Household Address and Contact Information

Homeless
Are your home and mailing addresses the same?
Delivery Type
Home Address 1
Home Address 2
City
State
County
Zip
Email
Home Phone
Work Phone
How would you like to be contacted?

Delivery Type
Mailing Address 1
Mailing Address 2
City
State
County
Zip

Cell Phone
Message/Emergency Phone

Adult Details

Person Sequence Number
Name
Gender
Date of Birth
Age
Place of Birth
US Citizen
Date of Entry into US
Marital Status

Person ID
Applying for Benefits
Relationship to Applicant
Have SSN
SSN

Legal Resident
PRUCOL Alien
Spouse Name

Race/s

Has Disability

Disability Start Date

Ever received temporary Cash assistance, SSI, Food Stamps or Medi-Cal

Name used when Cash Aid, SSI, Food Stamps or Medi-Cal receiver

Work More Than 100 Hrs

Long Term Care

Entry Date

Return Home in 6 Months

Enrolled in school fulltime

School Type

Requesting Medi-Cal coverage for unpaid expenses in the last 3 months?

Denied for any state or federal program

Employer Paid Insurance

Has a lawsuit pending due to an accident or injury?

Hospital or office visits

Other Expenses

Medical Home

Person Sequence Number

Name

Gender

Date of Birth

Age

Place of Birth

US Citizen

Date of Entry into US

Marital Status

Pregnant

Race/s

Has Disability

Disability Start Date

Ever received temporary Cash assistance, SSI, Food Stamps or Medi-Cal

Name used when Cash Aid, SSI, Food Stamps or Medi-Cal received

Work More Than 100 Hrs

Long Term Care

Entry Date

Return Home in 6 Months

Hispanic/Latino

Medi-Cal BIC Number

Name of Facility

Return Home

School Name

Prescribed Medications

Person ID

Applying for Benefits

Relationship to Applicant

Have SSN

SSN

Legal Resident

PRUCOL Alien

Spouse Name

Hispanic/Latino

Medi-Cal BIC Number

Name of Facility

Return Home

Enrolled in school fulltime

School Type

School Name

Requesting Medi-Cal coverage for unpaid expenses in the last 3 months?

Denied for any state or federal program

Employer Paid Insurance

Has a lawsuit pending due to an accident or injury?

Hospital or office visits

Prescribed Medications

Other Expenses

Medical Home

Child Details

Person Sequence Number

Person ID

Name

Applying for Benefits

Gender

Relationship to Applicant

Date of Birth

Have SSN

Age

SSN

Place of Birth

US Citizen

Legal Resident

Date of Entry into US

Date Legal Permanent Status Received

Marital Status

Spouse Name

Pregnant

Race/s

Hispanic/Latino

Mother Living in Home

Father Living in Home

Mother Deceased

Father Deceased

Mother's Identity known

Father's Identity known

Mother's Name

Father's Name

Custodial Parent ID (Mother)

Custodial Parent ID (Father)

Custodial Parent Name (Mother)

Custodial Parent Name (Father)

Is Mother Disabled

Is Father Disabled

Is Mother Employed

Is Father Employed

International Address (Mother)

International Address (Father)

Address1 (Mother)

Address1 (Father)

Address2 (Mother)

Address2 (Father)

City (Mother)

City (Father)

State (Mother)

State (Father)

Zip (Mother)

Zip (Father)

Has disability

Ever received temporary Cash assistance, SSI, Food Stamps or

Medi-Cal?

Long Term Care

School Type

School District Name

Requesting Medi-Cal coverage for unpaid expenses in the last 3 months?

Denied for any state or federal program

Employer Paid Insurance

Has an employer offered to pay all or some portion of your child's health coverage?

KP Premium Amount

EU Number

Person Sequence Number

Name

Gender

Date of Birth

Age

Place of Birth

US Citizen

Date of Entry into US

PRUCOL Alien

Marital Status

Pregnant

Race/s

Mother Living in Home

Mother Deceased

Mother's Identity known

Mother's Name

Custodial Parent ID (Mother)

Custodial Parent Name (Mother)

Is Mother Disabled

Is Mother Employed

International Address (Mother)

Address1 (Mother)

Address2 (Mother)

City (Mother)

State (Mother)

Zip (Mother)

Has disability

Ever received temporary Cash assistance, SSI, Food Stamps or Medi-Cal?

Name of Facility

School Name

PU Number

Person ID

Applying for Benefits

Relationship to Applicant

Have SSN

SSN

Legal Resident

Date Legal Permanent Status Received

Spouse Name

Hispanic/Latino

Father Living in Home

Father Deceased

Father's Identity known

Father's Name

Custodial Parent ID (Father)

Custodial Parent Name (Father)

Is Father Disabled

Is Father Employed

International Address (Father)

Address1 (Father)

Address2 (Father)

City (Father)

State (Father)

Zip (Father)

Long Term Care

School Type

School District Name

Requesting Medi-Cal coverage for unpaid expenses in the last 3 months?

Denied for any state or federal program

Employer Paid Insurance

Has an employer offered to pay all or some portion of your child's health coverage?

KP Premium Amount

EU Number

Name of Facility

School Name

PU Number

Household Relationships

Name	Relationship	Name
	Spouse	
	Parent	
	Parent	
	Spouse	
	Parent	
	Parent	
	Child	
	Child	
	Sibling	
	Child	
	Child	
	Sibling	

Income Details

Name

Income

Gross Monthly Amount

Address 1

City

Net Self Employment Income

Type of Work Indicated

Income Type

Frequency

Employer Name

State

Zip

Telephone

Self Employment Hours Worked

Name

Income

Gross Monthly Amount

Net Self Employment Income

Type of Work Indicated

Income Type

Frequency

Self Employment Hours Worked

Name

Income

Gross Monthly Amount

Income Type

Frequency

Net Self Employment Income
Type of Work Indicated
Name
Income
Gross Monthly Amount

Self Employment Hours Worked

Income Type
Frequency

Net Self Employment Income
Type of Work Indicated

Self Employment Hours Worked

Additional Household Information

Does any child listed on this application attend a school?

Does anyone listed on this application claim to be legally blind or disabled?

Eligibility Results

Name	Program_Name	Coverage_Type	Opt_Out	Reconsider	Gross Income	Net Ded"s	Net Income	Family Size	FPL %	DENIAL REASON

Notes

Application Signature Information

Program Name	Signature Type	Signature Date

Print Close